

Case Number:	CM15-0179883		
Date Assigned:	09/21/2015	Date of Injury:	04/27/2015
Decision Date:	11/13/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	09/14/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 63 year old male who sustained an industrial injury on 04-27-2015. He reported an injury to his left shoulder. He was initially diagnosed with tendonitis of the left shoulder. He was initially prescribed oral anti-inflammatory medication, a muscle relaxant, physical therapy and modified work. MRI of the left and right shoulder performed on 07-31-2015 demonstrated an unremarkable shoulder study. According to a progress report dated 08-05-2015, the injured worker reported left shoulder pain that was rated 7 on a scale of 1-10 with medication. Pain was described as sharp and stabbing with stiffness and weakness noted. Range of motion of the left shoulder was decreased with flexion, extension, abduction, adduction, external rotation and internal rotation. Deep tendon reflexes of the upper extremity was 2 plus out of 4. There was tenderness to palpation of the anterior shoulder, lateral shoulder and posterior shoulder. There was muscle spasm of the anterior shoulder, lateral shoulder and posterior shoulder. Impingement was positive. Diagnosis included left shoulder impingement syndrome. The treatment plan included Cyclobenzaprine 7.5 mg #90, Protonix 20 mg #60, Voltaren 100 mg #60, Topical Flurbiprofen 20% Baclofen 10% Dexamethasone Micro 0.2% Hyaluronic Acid 0.2% in cream base 240 grams and topical Amitriptyline Hcl 10% Gabapentin 10% Bupivacaine Hcl 5% Hyaluronic Acid 0.2% in cream base 240 Grams. Work status was not addressed in the 08-05-2015 report. On 08-14-2015, Utilization Review non-certified the request for Cyclobenzaprine 7.5 mg #90, Protonix 20 mg #60, Voltaren 100 mg #60, Topical Flurbiprofen 20% Baclofen 10% Dexamethasone Micro 0.2% Hyaluronic Acid 0.2% in cream base 240 grams and topical Amitriptyline Hcl 10% Gabapentin 10% Bupivacaine Hcl 5% Hyaluronic Acid 0.2% in cream base 240 Grams.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Cyclobenzaprine 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Regarding the request for cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Given this, the current request is not medically necessary.

Protonix 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, PPI.

Decision rationale: Regarding the request for Pantoprazole (Protonix), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Additionally, ODG recommends Nexium, Protonix, Dexilant, and AcipHex for use as 2nd line agents, after failure of omeprazole or lansoprazole. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use. Furthermore, there is no indication that the patient has failed first-line agents prior to initiating treatment with Pantoprazole (a 2nd line proton pump inhibitor). In the absence of clarity regarding those issues, the currently requested Pantoprazole is not medically necessary.

Voltaren 100mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Regarding the request for Voltaren, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Voltaren is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Voltaren is not medically necessary.

Topical Flurbiprofen 20% Baclofen 10% Dexamethasone Micro 0.2% Hyaluronic Acid 0.2% In Cream Base 240 Grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding this request, one of the components requested is topical baclofen. Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 113 of 127 state the following: "Topical Baclofen: Not recommended. There is currently one Phase III study of Baclofen-Amitriptyline-Ketamine gel in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer-reviewed literature to support the use of topical baclofen." Given these guidelines, the topical baclofen is not medically necessary. Since any formulation must have all components as recommended in order for the formulation to be medically necessary, this request is not medically necessary.

Topical Amitriptyline Hcl 10% Gabapentin 10% Bupivacaine Hcl 5% Hyaluronic Acid 0.2% In Cream Base 240 Grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: With regard to this request for a topical compounded cream that contains gabapentin as a component, the CPMTG does not recommend topical gabapentin. On page 113 of the Chronic Pain Medical Treatment Guidelines, the following is stated: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." The guidelines further state that if one drug or drug class of a compounded formulation is not recommended, then the entire compounded formulation is not recommended. Therefore, the topical gabapentin component is not recommended, and the entire formulation is not medically necessary.